



# AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

## INFORMATION MAY BE DISCLOSED BY:

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_  
(Street, City, Zip Code)

## INFORMATION MAY BE DISCLOSED TO:

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_  
(Street, City, Zip Code)

Other method of communication: \_\_\_\_\_

## INFORMATION TO BE DISCLOSED: (Initial Selection) **Note: You must INITIAL next to your selection(s). Check marks or X is not accepted.**

\_\_\_\_ General Medical Record(s), including STD and TB      \_\_\_\_ Progress Notes      \_\_\_\_ History and Physical Results  
\_\_\_\_ Immunizations      \_\_\_\_ Family Planning      \_\_\_\_ Prenatal Records      \_\_\_\_ Consultations  
\_\_\_\_ Diagnostic Test Reports (Specify Type of test(s)) \_\_\_\_\_  
\_\_\_\_ Other: (specify) \_\_\_\_\_

## I specifically authorize release of information relating to: (initial selection) **Note: You must INITIAL next to your selection(s). Check marks or X is not accepted.**

\_\_\_\_ HIV test results for non-treatment purposes      \_\_\_\_ Substance Abuse Service Provider Client Records  
\_\_\_\_ Psychiatric, Psychological or Psychotherapeutic notes      \_\_\_\_ Early Intervention      \_\_\_\_ WIC

## PURPOSE OF DISCLOSURE:

\_\_\_\_ Continuity of Care      \_\_\_\_ Personal Use      \_\_\_\_ Other (specify) \_\_\_\_\_

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**REDISCLOSURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

**REVOCACTION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

\_\_\_\_\_  
Client/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Representative's Relationship to Client

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

**Client Name:** \_\_\_\_\_

**ID#:** \_\_\_\_\_

**DOB:** \_\_\_\_\_